MassHealth Level I Preadmission Screening (PAS)

Commonwealth of Massachusetts
EOHHS
www.mass.gov/masshealth

This form must be completed by the nursing facility for **all individuals** who, regardless of payment source, are admitted to a nursing facility. This form **must be kept permanently** in the resident's medical record. A licensed nurse or licensed social worker employed by the nursing facility must complete both sides of this form before the applicant's admission, as mandated by the federal Omnibus Budget Reconciliation Act (OBRA) of 1987.

Nursing Facility Provider Information	Nursing Facility Applicant Information	
Provider number	MassHealth ID or SSN	
Name	Name	
Address	Address	
City, ZIP code	City, ZIP code	
Telephone number	Date of birth	Gender ☐ M ☐ F

Section 1: PAS for Mental Retardation or Developmental Disability

1. Does the nursing-facility applicant have a documented diagnosis or treatment history of mental retardation or developmental disability? ☐ yes ☐ no
2. Has the nursing-facility applicant received services for mental retardation or developmental disability from an agency that serves individuals with mental retardation and/or developmental disability? ☐ yes ☐ no
3. Does the nursing-facility applicant exhibit any evidence that may indicate mental retardation or developmental disability? ☐ yes ☐ no

If you answered **no** to all questions in Section 1, skip Section 2 and proceed to Section 3.

Section 2: Convalescent Care (*following an acute inpatient hospital stay*)

Is the nursing-facility applicant seeking admission for convalescent care as certified by a physician not to exceed 30 days directly following an acute-inpatient-hospital stay? ☐ yes ☐ no

Section 3: Level I Determination for Mental Retardation or Developmental Disability

Check all that apply.

☐ Level II PAS is not indicated because there is no diagnosis or evidence of mental retardation or developmental disability.

☐ Level II PAS is not indicated because the applicant is seeking admission for convalescent care as certified by a physician not to exceed 30 days directly following an acute-inpatient-hospital stay.

☐ **Level II PAS is indicated and must be completed before admission.** Date of completion: _____

☐ Approved by DMR for nursing-facility admission. (The DMR approval letter must be in the medical record.)

Date of nursing-facility admission: _____

Related diagnoses and comments: _____

Signature: _____ RN, LPN, LSW (Circle one.) Date: _____ Time: _____

Note: You must notify DMR only when MR/DD is indicated.

Did you call and notify DMR on the day of admission? ☐ yes (date) _____ ☐ no

Did you fax this page within 48 hours to DMR? ☐ yes (date) _____ ☐ no

Please complete other side. ►

Name of Applicant: _____

Section 4: PAS for Mental Illness

1. Does the nursing-facility applicant have a documented diagnosis or treatment history of any of the following major mental disorders? Check all that apply.

Psychoses

- ☐ Schizophrenia
- ☐ Paranoia
- ☐ Atypical psychosis

Affective Disorders

- ☐ Schizo-affective disorder
- ☐ Bipolar disorder (formerly manic depression)
- ☐ Unipolar depression more than **10 years** (date of diagnosis: _____)

Severe Anxiety and Somatoform Disorders (All must apply for Level II PAS referral.)

- ☐ Two years' duration with documented symptoms in the last six months
- ☐ Inpatient psychiatric treatment for anxiety disorder
- ☐ Psychoactive medication(s) administered for anxiety disorder (date of diagnosis: _____)

2. Has the nursing-facility applicant ever received any of the following treatments for unipolar depression?

a. Inpatient or outpatient psychiatric treatment ☐ yes ☐ no
b. Electroconvulsive therapy ☐ yes ☐ no
c. Psychoactive medications ☐ yes ☐ no

3. Does the nursing-facility applicant exhibit any evidence of a major mental illness? ☐ yes ☐ no

If you answered **no** to all questions in Section 4, skip Section 5 and proceed to Section 6.

Section 5: Primary Diagnoses/Conditions

Does the nursing-facility applicant have any of the following diagnoses or conditions or meet any of the following descriptions? (Note: **End Stage (ES)** is defined as severe, debilitating, and bed-bound or bed-to-chair). Check all that apply.

- ☐ Alzheimer's disease or other dementia (requires supporting documentation)
- ☐ Comatose
- ☐ Ventilator dependent
- ☐ Terminal illness with less than six-month prognosis as certified by a physician
- ☐ Severe brain injury
- ☐ **ES** COPD with 24-hour oxygen
- ☐ **ES** CHF with 24-hour oxygen
- ☐ **ES** Amyotrophic lateral sclerosis (ALS)
- ☐ **ES** Huntington's chorea
- ☐ **ES** Parkinson's disease
- ☐ Unipolar depression, less than 10 years' duration (date of diagnosis: _____)
- ☐ Convalescent care as certified by a physician not to exceed 30 days directly following an acute inpatient hospital stay (this does not include a psychiatric hospitalization).

Section 6: Level I Determination for Mental Illness

Check all that apply.

- ☐ Level II PAS is not indicated because there is no diagnosis as listed or evidence of mental illness as noted in **Section 4**.
- ☐ Level II PAS is not indicated because the applicant has one of the diagnoses or conditions in **Section 5**.
- ☐ **Level II PAS is indicated and must be completed before admission.** Date of completion:_____
- ☐ Approved by Health and Education Services (HES) on behalf of the Department of Mental Health for nursing-facility admission. (The HES approval letter must be in the medical record.)

Comments: _____

List psychoactive medication(s) and dosage: _____

_____

Signature: _____ RN, LPN, LSW Date: _____ Time: _____
(Circle one.)

Level I and Level II PAS must be kept permanently in the medical record.